

Wauwatosa School District Employees

HSA Qualified - High Deductible Health Plan Base Plan

October 1, 2020 - September 30, 2021

4 11	Benefit Description	In - Network	Out - of - Network
	Benefit Description	III - Idetwork	Out - Ot - Network
Annual Plan V	ear Deductible (This is a combined limit	· · · · · · · · · · · · · · · · · · ·	
	etwork and Out-of-Network benefits, Family	\$1,500 single**	\$3,000 single
deductible must be met in total before coinsurance		\$3,000 family**	\$6,000 family
applies) *		(Per Plan Year)	(Per Plan Year)
Coinsurance Percentage (What <u>you</u> pay after deductible)		0%	30%
Annual Out-of-Pocket Maximum (This is a combined			
maximum between In-Network and Out-of-Network benefits		\$1,500 single	\$3,500 single
and includes deductible amount paid,		\$3,000 family	\$7,000 family
	cation Penalty for Out of Network Inpatient	NA	\$200 per confinement (does not apply to annual out-of- pocket maximum)
Admissions			<u> </u>
	etime Maximum Benefit Limit	Unlim	
Home and Off Emergency R		0% after deductible 30% after deductible 0% after in-network deductible	
Urgent Care	COM VISIC		
,	agnostic Radiology and Pathology	0% after deductible	30% after deductible
		0% after deductible	30% after deductible
	oital Facility and Services	0% after deductible	30% after deductible
	spital Facility and Services	0% after deductible	30% after deductible
Covered Dent		0% after deductible	30% after deductible
Ambulance So	ervices	0% after deductible 0% after deductible	0% after in network deductible
Oral Surgery	and Cardon and		30% after deductible
	cal Equipment Id Periodic Exams with Preventive Tests	0% after deductible 0%, not subject to the deductible	30% after deductible
		0 %, not subject to the deductible	30% after deductible
detai i s)	ventive Care Screenings (See SPD for further	0%, not subject to the deductible	30% after deductible
contraceptive	Coverage (Includes all FDA approved methods (as prescribed), sterilization nd patient education and counseling)	0%, not subject to the deductible	30% after deductible
Immunizations	3	0%, not subject to the deductible	30% after deductible
Chiropractic & medical neces	Physical Therapy (Unlimited, based upon ssity)	0% after deductible	30% after deductible
	oital Services for Nervous or Mental Disorders, and Drug Abuse	0% after deductible	30% after deductible
	rvices for Nervous or Mental Disorders, ad Drug Abuse	***	30% after deductible
	reatment Arrangements for Nervous or Menta	0% after deductible	
	coholism and Drug Abuse	0% after deductible	30% after deductible
	g Care in a Licensed Skilled Nursing Facility nefit limit of 90 days per participant, per year)	0% after deductible	30% after deductible
Home Health	Care Services	0% after deductible	30% after deductible
Prescription Drugs on <u>UHC</u> Preventive List. Copays accumulate toward annual out of pocket maximum.		1 - 34 days at Retail: \$10 copay Tier 1 \$20 copay Tier 2 \$30 copay Tier 3 35 - 60 days at Retail: \$20 copay Tier 1 \$40 copay Tier 2 \$60 copay Tier 3 61 - 90 days at Retail: \$20 copay Tier 1 \$60 copay Tier 2 \$90 copay Tier 3	90 days through Mail Order: \$20 copay Tier 1 \$40 copay Tier 2 \$60 copay Tier 3
Dracorintiae D	trude not on LIHC Preventive List	0% after deductible	30% after deductible
Prescription Drugs <u>not on UHC</u> Preventive List		O /o andi deductible	1 30 % arrei deductible

^{*} Annual Plan Year runs October 1 through September 30. Deductible resets every October 1.
** Deductibles may be adjusted annually in compliance with regulatory requirements.

This is a brief description of your benefits. For further information, please refer to the benefit booklet, which can be found on line at www.uhc.com. In order to view, you must log into www.myuhc.com, using your member id number located on you UHC ID card.



Wauwatosa School District Employees

HSA Qualified - High Deductible Health Plan ACA Plan

October 1, 2020 - September 30, 2021

Benefit Description	In - Network	Out - of - Network
Annual Plan Year Deductible (This is a combined limit		
between In-Network and Out-of-Network benefits, Family	\$5,000 single**	\$10,000 single
deductible is an embedded deductible - individual	\$10,000 family**	\$20,000 family
maximums apply *	(Per Plan Year)	(Per Plan Year)
Coinsurance Percentage (What you pay after deductible)	20%	40%
Annual Out-of-Pocket Maximum (This is a combined	\$6,000 single	\$12,000 single
maximum between In-Network and Out-of-Network benefits	\$12,000 single \$12,000 family	\$12,000 single \$24,000 family
and includes deductible amount paid.	(Per Plan Year)	(Per Plan Year)
Family out-of-pocket has an individual maximum	(Fel Flati Tear)	(Fei Fiail Teal)
Non-Precertification Penalty for Out of Network Inpatient Admissions	NA	\$200 per confinement (does not apply to annual out-of- pocket maximum)
Participant Lifetime Maximum Benefit Limit	Unlim	
Home and Office Visit	20% after deductible	40% after deductible
Emergency Room Visit	20% after in-nety	vork deductible
Urgent Care	20% after deductible	40% after deductible
Outpatient Diagnostic Radiology and Pathology	20% after deductible	40% after deductible
Inpatient Hospital Facility and Services	20% after deductible	40% after deductible
Outpatient Hospital Facility and Services	20% after deductible	40% after deductible
Covered Dental Services	20% after deductible	40% after deductible
Ambulance Services	20% after deductible	20% after in network deductible
Oral Surgery	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Adult and Child Periodic Exams with Preventive Tests	0%, not subject to the deductible	40% after deductible
Women's Preventive Care Screenings (See SPD for further details)	0%, not subject to the deductible	40% after deductible
Contraceptive Coverage (Includes all FDA approved contraceptive methods (as prescribed), sterilization procedures, and patient education and counseling)	0%, not subject to the deductible	40% after deductible
Immunizations	0%, not subject to the deductible	40% after deductible
Chiropractic & Physical Therapy (Unlimited, based upon	20% after deductible	40% after deductible
medical necessity) Inpatient Hospital Services for Nervous or Mental Disorders,	20,0 0101 0000000	40% after deductible
Alcoholism and Drug Abuse	20% after deductible	TO 79 BITCH GEGGERATE
Outpatient Services for Nervous or Mental Disorders, Alcoholism and Drug Abuse	20% after deductible	40% after deductible
Transitional Treatment Arrangements for Nervous or Mental Disorders, Alcoholism and Drug Abuse	20% after deductible	40% after deductible
Skilled Nursing Care in a Licensed Skilled Nursing Facility (Maximum benefit limit of 90 days per participant, per year)	20% after deductible	40% after deductible
Home Health Care Services	20% after deductible	40% after deductible
Prescription Drugs on <u>UHC</u> Preventive List. <i>Copays</i> accumulate toward annual out of pocket maximum.	1 - 34 days at Retail: \$10 copay Tier 1 \$20 copay Tier 2 \$30 copay Tier 3 35 - 60 days at Retail: \$20 copay Tier 1 \$40 copay Tier 2 \$60 copay Tier 3 61 - 90 days at Retail: \$20 copay Tier 1 \$60 copay Tier 1 \$60 copay Tier 2 \$90 copay Tier 3	90 days through Mail Order: \$20 copay Tier 1 \$40 copay Tier 2 \$60 copay Tier 3
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Prescription Drugs not on UHC Preventive List	20% after deductible	40% after deductible

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